Frequently Asked Questions
for Participants

What is the Bureau of Developmental Disability Services?
It is a part of the Division of Medicaid and oversees eligibility, prior authorization, and quality outcomes for services to adults with developmental disabilities.

What is care management?
Care management is used to improve the quality of care you receive and to control costs by setting policies for the kind of services you receive and how you access them. The purpose of care management is to make sure you receive the right care, in the right place, at the right price, and with the right outcomes. Our goal is to improve your health and safety, and to promote your rights, self-determination, and independence.

How do I know if I'm eligible for adult developmental disability services?
The Idaho Centers for Disability Evaluations will have an Independent Assessor Provider do an evaluation and decide if you are eligible for adult services. Eligibility is based on the rules established by the state and federal government and the federal Center for Medicare and Medicaid Services.

Who are the Independent Assessors and what do they do?
The Independent Assessor is a provider who has been contracted by the Department to review your documentation, do your assessment, and determine if you're eligible. If you're eligible, the assessor will authorize your plan. The assessor doesn't work directly for the Department or for Medicaid and can't provide services to you. The assessor can approve services but can't deny them.

What is the SIB-R?
The Scales of Independent Behavior – Revised (SIB-R) is an assessment tool that is used by Medicaid to determine your ability to function on your own. To get an accurate assessment, someone who knows you very well is asked a series of questions about you. The SIB-R is given by an Independent Assessor Provider at the Idaho Center for Disabilities Evaluation.

Can I get a copy of my SIB-R assessment?
You, your guardian, and your plan developer can get a copy of your SIB-R results, but you can't get a copy of the specific answers to each question. To get a copy of your SIB-R results, call the Idaho Center for Disabilities Evaluation.

What is prior authorization?
Prior authorization means that the services you need are approved by Medicaid before you begin receiving them. To get your services prior authorized, you, your person centered planning team, and the independent assessor must agree on your Individual Support Plan. Once you agree, your completed plan can be authorized by the Regional Medicaid Services Unit, you can begin receiving the services, and your provider can bill for those services.

If you need to change any of the services on your plan, you must send the changes to the assessor in writing so the new services can be prior authorized.

What services need to be prior authorized?
- Home and Community Based Waiver services.
- Idaho State School and Hospital Developmental Disabilities Waiver services.
- Developmental Disability Agency services.
- Targeted Service Coordination/Plan Developer services for adults.
- Transportation to and from places where you receive services.

What does it take for my services to be prior authorized?
Before your services can be prior authorized they must:
- Meet your needs.
- Be identified on your plan.
- Be agreed upon by you through the person centered planning process.
- Be within the budget guidelines.

What is my budget?
It is the total amount of money Medicaid can spend on your services each year. The Department determines your annual budget by measuring your ability to function, your behavioral limitations, your medical needs, and other factors related to your disability.

Who will help me manage my budget and services?
The assessor will discuss your plan with you and your plan developer, to agree on services and a budget.

If my service needs are more than my budget, what will happen?
- If your plan and budget can't be determined by the assessor, they'll be sent to the Regional Care Manager for review.
- The Regional Care Manager will then approve your plan, approve parts of your plan, or deny your plan.
- If the Regional Care Manager approves the plan, you can begin receiving services.
- If the Regional Care Manager approves parts of the plan, you can begin receiving the approved services while the other services are being considered.
- If the Regional Care Manager denies services on your plan, you can ask for a *Reconsideration of Decision* by a Central Office Care Manager.

Does this mean I will lose services?
Some services might not be approved if:

- You have duplicate services on your Plan.
- You have services that don't meet your needs based on your assessment.
- You can receive the services that meet your needs at a lower price.

If you have special needs or circumstances that require you to have specific, or more expensive services, they will be identified and the Care Manager might be able to approve them.